Project Lifesaver

More Information Request:

Caregiver(s) Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone:_____

Patient's Illness: Please check the appropriate box:

- ☐ Alzheimer's Disease
- ☐ Autism
- ☐ Down's Syndrome
- ☐ Other Dementia

Other related disorders that cause wandering, bolting, and/or running.
Please Explain: _____
_____

Mail this completed form to the:

Columbia County Sheriff's Office
c/o Project Lifesaver - CCSO
Attn: Community Services Unit
2273 County Camp Road
Appling, Georgia 30802
or contact:
706-541-2856